Child Fatalitiy Review Program

Goals:
The Child Fatality Review mission is to reduce preventable child fatalities through systematic, multidisciplinary reviews of child fatalities in Arizona.

Program Components:
The State and Local Child Fatality Review Teams are made up of volunteers representing a broad range of professions and agencies serving children throughout Arizona. Local Child Fatality Teams review the circumstances surrounding child deaths in their counties and identify factors that may have contributed to each death. The State Child Fatality Review Team produces an annual report on the incidence and causes of child deaths. The report also includes recommendations to reduce preventable child deaths. The annual report is located on-line at: www.azdhs.gov/phs/owch/cfr.htm.

Funding
Child Fatality Review Fund and DES

Target Audience:
All Arizonans and specifically community providers, legislators, elected officials and policy makers

Why is this Program Needed?
To provide data of child fatalities through systematic, multidisciplinary reviews of child fatalities in Arizona in to reduce preventable child fatalities

What has the Program Achieved?
Some of the past recommendations of the program have now become reality. For example, because of concerns regarding deaths associated with unsafe sleep environments, Child Protective Services developed a safe sleep brochure to disperse to families. Statewide concern for teen motor vehicle crashes resulted in graduated driving license requirements, which will become effective in 2008. The program has also recommended increased supervision of children around water and pool fencing. In 2006, Maricopa County drowning deaths among children younger than five years of age dropped to the lowest rate since the state started tracking the problem, and child deaths in Maricopa County swimming pools also dropped to the lowest rate on record.

During this reporting period, Arizona's Child Fatality Review Teams began participating in the Child Death Review Case Reporting System through the National Center for Child Death Review. In an effort to standardize reporting of child fatalities across states, the Arizona local review teams used a reporting tool developed by the National Center for the first time in 2006. This new reporting tool was developed in collaboration with child fatality review programs across the nation and enables comparison of Arizona fatality data with other states.

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In addition, this comprehensive information facilitates better understanding of the circumstances surrounding child deaths and can ultimately be used to develop strategies to reduce child deaths in Arizona.

Child Fatality Review Program staff members have also participated in efforts to improve the National Child Death Review Reporting System, including development of a program to interpret data coding.

For Additional Information Contact:

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